CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

Discrepancy Response

Date: _____

Member Name: _____ Agency Name: _____

SSN: _____ GIR Name: _____

Org. Proc. Code: _____ Phone #: _____

DCMS USE ONLY

Int Mth

REQUESTING: (*Mark Only One*)

_____ Delay Termination for CFT Member

_____ Reinstate Coverage

_____ Adjustment Indicated Below

ATTACHMENTS:

Received

_____ Copy of Payroll / Direct Payment Report

_____ All Necessary Membership Documentation

ADJUSTMENTS:

_____ **PAYROLL** Adjustment Processed on Pay Period(s): _____

Health $ _____ Life $ _____ Dental $ _____

_____ **CREATE** (Add) Pay Record(s):

PAY PERIOD(S)		PAY CODE	ELIG CODE	Int	Date
_____	THRU _____	_____	_____	_____	_____
_____	THRU _____	_____	_____	_____	_____

_____ **CORRECT** Pay Record Code(s):

PAY PERIOD(S)		ORIG INFO	CORR INFO		
_____	THRU _____	_____	_____	_____	_____
_____	THRU _____	_____	_____	_____	_____
_____	THRU _____	_____	_____	_____	_____

_____ **TRANSFER** Member Paid Premium:

Pay Period(s) Member Is / Will Be Overpaid: _____

Health $ _____ Life $ _____ Dental $ _____

Pay Period(s) Member Is / Will Be Underpaid: _____

Health Life Dental

Carrier/Code _____ $_____ Carrier/Code _____ $_____ Carrier/Code _____ $_____

REMARKS: _____

_____

_____

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

DIRECT PAYMENT SUMMARY

Date _____

Coverage Period (Mo/Yr) _____ Agency/Facility _____

Type Payroll: (circle one) S/M Mo Prepared By _____

Payroll Code _____ Phone ( ) _____

A. DIRECT PAYMENTS BY CARRIER BEING SUBMITTED WITH THIS REPORT:

Carr Code	HEALTH CARRIER	Health dollar Amount	Carr Code	DENTAL CARRIER	Dental Dollar Amount
____	_____	$_____	____	_____	$_____
____	_____	$_____	____	_____	$_____
____	_____	$_____	____	_____	$_____
____	_____	$_____	Carr Code	LIFE CARRIER	Life Dollar Amount
____	_____	$_____			
____	_____	$_____	____	_____	$_____
____	_____	$_____	____	_____	$_____

B. TOTAL DIRECT PAYMENTS SUBMITTED WITH THIS REPORT – ALL CARRIERS $_____

NOTE: A check or treasurer's draft, made payable to CMS Group Insurance Fund, must accompany this report for the Amount indicated on Line B.

FOR OFFICE USE ONLY

CENTRAL MANAGEMENT SERVICES – BENEFITS SYSTEMS DIVISION
AGENCY ORGANIZATIONAL PROCESSING CODE FILE SET-UP FORM

AGENCY NAME: _____ **CUSAS CODE:** ____ ____ ____

CONTACT NAME AND PHONE NUMBER: _____ (_____)_____-_____

GIR _____ **GIP**_____ **FLEX REP** _____ **OPTION:** ☐ **ADD** ☐ **CHANGE** ☐ **REMOVE**

ORG PROC CODE: _____ _____ _____ **EFFECTIVE DATE:** _____

FIRST NAME: _____ **MI** ___ **LAST NAME:** _____

ADDRESS (1): _____**(2)**_____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____ - _____

PHONE: (_____) _____ - _____ **EXT:** _____ **FAX NUMBER:** (_____) _____ - _____ **EXT:** _____

E-MAIL ADDRESS: _____

RACF ID: _____ **SOCIAL SECURITY NUMBER:** _____ - _____ - _____

ORG PROC CODE(S) PERSON NEEDS ACCESS TO: _____ _____

PLEASE CHECK WHICH SYSTEMS THE PERSON NEEDS ACCESS TO BELOW:

☐ **MEMBERSHIP FULL UPDATE** ☐ **MEMBERSHIP LIMITED UPDATE** ☐ **MEMBERSHIP INQUIRY**
☐ **GIFCS PAY ADJUSTMENT** ☐ **FLEXIBLE SPENDING UPDATE** ☐ **FLEXIBLE SPENDING INQ.**

Please indicate the date by which the person needs to be trained: _____

REPORTS WILL BE PROVIDED ONLINE ONLY. IF YOU WANT PRINTED REPORTS, YOU MAY SUBMIT A WRITTEN REQUEST, ALONG WITH JUSTIFICATION, TO THE BENEFITS SYSTEMS DIVISION FOR REVIEW AND APPROVAL.

IF THIS PERSON WILL RECEIVE REPORTS FROM THE MEMBERSHIP, GIFCS OR FSA SYSTEMS AND WILL PRINT ONLINE REPORTS FROM THE MAINFRAME RATHER THAN THE INTERNET, PROVIDE THE PRINTER ID _____.

Note: *The Benefits Systems Division must receive a written request from the agency to: 1) establish a new GIR/P or Flex Rep, 2) remove or replace an existing GIR/P or Flex Rep, or 3) change a GIR/P or Flex Rep's information. If access is requested to one of GID's systems, the GIR/P or Flex Rep must be trained by GID before access will be granted. Once the Benefits Systems Division receives the written request for access, agencies will be contacted by GID regarding the necessary training.*

INSTRUCTIONS

AGENCY NAME – indicate the name of your agency in this space.

CUSAS CODE – indicate the three-digit Comptroller CUSAS code for your agency in this field.

CONTACT NAME AND PHONE NUMBER – indicate the name and phone number of the Group Insurance Representative (GIR) for your agency. All requests to add, change or remove GIR/P or Flex Rep information must be approved by the GIR.

GIR/GIP/FLEX REP – place an "x" or checkmark next to the one(s) that applies.

OPTION: ADD/CHANGE/REMOVE – check the box to indicate why this form is being submitted. The 'Add ' box should only be checked if you are adding a new person and need to establish a new organizational processing code (OPC). If you are replacing a person who is in an existing OPC, check the 'Change' box. The 'Change' option should also be checked to update address, phone, email address, etc. The 'Remove' box should only be checked if you want to eliminate an OPC. Note, there may be active employees on the Membership System under the OPC you are eliminating. If so, you need to provide instructions as to what OPC code should replace the one that is being eliminated so GID can update the employee's records.

ORG-PROC-CODE – this code uniquely identifies each GIR/P or Flex Rep at your agency. If you are adding a new person, indicate the Organizational Processing Code (OPC) that you would like to assign to the person. Please note that this code must be different from any other person's code within your agency. If you are changing the information for a person in an existing OPC or requesting removal of an OPC, enter the code that the change applies to or that is being removed.

EFFECTIVE DATE – indicate when the add, change or removal is effective.

FIRST NAME/MIDDLE INITIAL (MI)/LAST NAME – indicate the person's full name as you want it to appear on all Group Insurance documentation.

ADDRESS – indicate the person's work address. All mail for that person will be sent to this address.

PHONE #, FAX # & EMAIL ADDRESS – indicate the phone number, fax number and email address for the person in the space provided.

RACF ID & SOCIAL SECURITY NUMBER – if the person has been assigned a RACF security code, enter the code in the space provided. If the person does not have a security code, write 'None'. Provide the person's SSN.

ORG PROC CODE ACCESS – enter each 9-digit organizational processing code to which the person needs access.

SYSTEM ACCESS – if the person needs on-line access to the Membership System, Group Insurance Financial Control System (GIFCS) or Flexible Spending System (FSA), check the box(es) that identify the systems to which they need access. Note, there are three levels of access for the Membership System: full update (can process new enrollments, addition/deletion of dependent coverage, changes in plans, etc.), limited update (can process only limited changes such as changes of address, type/subtype changes, terminations, etc.), and inquiry only (can view but not update information). If Membership access is requested, check only one of the three types of access.

REPORT INFORMATION - Reports will be provided online only. If you want printed reports, you may submit a written request, along with justification, to the benefits systems division for review and approval. If the user does not have internet access and will use the mainframe to access online reports via Mobius, please include the user's mainframe printer id in the space provided.

QUESTIONS: If you have any questions regarding the completion of this form, please contact the Benefits Systems Division at (217) 558-3484 or (217) 558-3486.

Please return this form to: **Benefits Systems Division**
201 East Madison, Suite 1B
Springfield, IL 62794-9208
Fax #: 217-524-7541

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

Special GIFCS Reports – Sorting Sequence Request

Agencies may request three specialized discrepancy reports that may assist with identifying the highest dollar discrepancy or CFT by the sorting sequence. If the agency is requesting a report for each facility, one (1) form needs to be filled out for each facility. If ordered by facility, ach facility will be separated for easy distribution. Only one (1) form should be completed if the agency does not want facilities separated.

Please answer all the questions below. This information will assist Central Management Services, Group Insurance Division in completing the request accurately.

1. What is the agency Organizational Processing Code? ☐☐☐

2. Does the agency want this report for all their facilities? Yes ☐ No ☐

   If Yes, then skip to item 3.
   If No, what facility Organizational Processing Code is requested? ☐☐☐

3. Is the default tolerance of $3.50 (plus or minus) acceptable? Yes ☐ No ☐

   If Yes, then skip to item 4.

   If No, what tolerance level, in dollars, is being requested? $ ☐.☐

4. What sequence type report is requested?

   Highest dollars (highest negative to smallest positive) (GIFCMR24-1) ☐
   Last name and then dollars (GIFCMR24-2) ☐
   Highest CFT values, then highest Priorities, then dollars (GIFCMR24-3) ☐

5. How many copies of the report are requested? ☐

Mail request to: Central Management Services
Group Insurance Division
Attn: Analysis and Resolution Unit, Dan Ewald
201 E. Madison, Suite 2B, PO Box 19208
Springfield, IL 62794-9208

Agency Completed
Requested by: _____ Date _____ Phone No._____

GID Use Only: _____

Turnaround Document? (Y/N) ____

MEMBERSHIP CORRECTION FORM

Member Name: _____ SSN: _____

Corrected Name: _____ Corrected SSN: _____

Org. Proc. Code: _____

	CHANGE TO	START DATE	END DATE
MEMBER BIO.			
____ Marital Status			
____ Medicare Status			
____ Part A Effective	Free (Y / N)		
____ Part B Effective			
MEMBER GROUP			
____ Type Enrollee			
____ Part-time %			
____ Deduct Freq.			
____ Qual Chg Reason (w/request date)			
____ Org. Proc. Code			
____ Cusas Code			
____ Work County			
MEMBER HEALTH			
____ Active/Term (T/W code)			
____ Carrier (Chg. code)			
____ Est. Ann. Salary			
MEMBER DENTAL			
____ Active/Term (T/W code)			
____ Carrier (Chg. code)			
MEMBER LIFE			
____ Active/Term (T/W code)			
____ Basic Life Units			
____ Optional Life			
____ A.D.&D.			
____ Spouse Life			
____ Child Life			
Certificate Approval Date:			

THINGS TO REMEMBER

* Marriage or divorce is a *Change in Status*.

All Medicare changes require a copy of the Medicare Card.

All Medicare effective dates are the 1st of the month.

* Going off or returning to payroll (Type 10xx to 60xx or vice versa), or changing back and forth from part-time to full-time is a *Change in Status*.

Changes in Part-time % will alter Basic Life Units.

All Deduct Freq. effective dates are the 1st of the month.

ENTER *Change in Status* Codes under Qualifying Change Reason.

*Request date *must be* within 60 days of the *Change in Status.*

H/D/V plans must all be active or terminated. Please provide term/waive code, if applicable.

* Carrier change requires *Change in Status*.

Estimated annual salary only changes for reduction, retirement or return to state employment from termination or retirement at a different salary.

H/D/V plans must all be active or terminated. Please provide term/waive code, if applicable.

* Carrier change requires *Change in Status.* Carrier Change Reason code corresponds to this.

Please provide term/waive code, if applicable.

Basic Life Units are affected by any change in base pay, including changes in part-time % (Admin. Bulletin 99-4).

Evidence of Insurability (health certificate) is required when spouse, child or optional life is added; *Change in Status* is not required to add spouse or child life.

Change in Status *is not required* for a change in life coverage greater than $50,000 (total of basic+optional).

Effective date of change in life coverage must be within 90 days of the health certificate approval date.

GIR/GIP Signature: _____ *Date:* _____

GIR Phone #: _____

Attachments: _____

**** Note:** Change in Status Requires Member's signature*

Member Name: _____ Member SSN: _____

Dep. Name: _____ Corrected Name: _____

Dep. SSN: _____ Corrected SSN: _____

Date of Birth (D.O.B.) _____ Corrected D.O.B. _____

(Please attach extra sheet, if necessary)

DEPENDENT BIO.	CHANGE TO	START DATE	END DATE
___ Medicare Status			
___ Part A Effective	Free (Y / N)		
___ Part B Effective			
DEPENDENT GROUP			
___ Type Dependent			
(T/W Code)			
___ Relationship Code			
___ Recert Date (Ann. 19/23)			
DEPENDENT HEALTH			
___ Active / Term			
(T/W Code)			
___ Carrier			
(Chg. Code)			
___ PCP			
DEPENDENT DENTAL			
___ Active / Term			
(T/W Code)			
___ Carrier			
(Chg. Code)			
___ PCP			
DEPENDENT LIFE			
___ Active / Term			
(T/W Code)			
Certificate Approval Date			

THINGS TO REMEMBER

All Medicare changes require a copy of the Medicare Card.

All Medicare effective dates are the 1st of the month.

Include termination reason code, if necessary. NOTE: 8050 does NOT generate COBRA letter. Rel. code 10 ("other") must be continuously enrolled prior to 2/11/83 and eligible to be claimed on member's taxes. Recertify annually.

Annual Recert date must be 9/1. Recert Date for age 19 and 23 is dependent's birthdate. Note: Dependents age 19 and 23 may have to recertify twice in the same year.

H/D/V plans must *all* be active or terminated. Please provide term/waive code, if applicable.

Dependent carrier must match member's carrier.

PCP code required for new dependents.

H/D/V plans must *all* be active or terminated. Please provide term/waive code, if applicable.

Dependent carrier must match member's carrier.

PCP code required for new dependents.

Note: All liability is generated from Member Life Data. Please provide term/waive code, if applicable.

Effective Date of change in life coverage must be within 90 days of the Health Certificate approval date.

Other: _____

Additional Comments: _____

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NONPAYROLL MEMBER AND DIRECT PAYMENT REPORT

Date _____ Agency/Facility _____ Preparer's Name & Phone # _____

Member's Name (Last, First, MI) (1)					Social Security Number (2)			Pay Code (3)	Ded Freq (4)	Birthdate (5)	PT % (6)	Elig. Code (7)	Basic Life Units (8)
Health Carrier Code (9)	Health Opt. Code (10)	Health Carrier Dollar Amount (11)	Dental Code (12)	Dental Opt. Code (13)	Dental Carrier Dollar Amount (14)	Life Carrier Code (15)	Life Opt. Code (16)	Life Carrier Dollar Amount (17)	Total Amount Paid 11+14+17 (18)	Pay Period Coverage Dates Ending (19)		Beginning (20)	
					— —				/ /				
		$			$			$	$				
					— —				/ /				
		$			$			$	$				
					— —				/ /				
		$			$			$	$				
					— —				/ /				
		$			$			$	$				
					— —				/ /				
		$			$			$	$				

*** Note: All fields MUST be filled.**

DEDUCTION FREQUENCY:
M = Monthly
S= Semi-Monthly

Agency Name: _____ Org. Proc. Code: _____

Member Name: _____ Member SSN: _____-_____-_____

Dependent Name: _____ Dependent SSN: _____-_____-_____

Mbr Signature: _____ Date: _____

GIR Signature: _____ Date: _____

MEMBER AND/OR DEPENDENT ADDRESS CHANGE FORM

Member Address Change:

Effective Date of Change: _____/_____/_____

Residential Address

_____

_____

City: _____

State: _____

ZIP: _____ + _____

Resident county: _____

Country: _____

(for foreign address only)

Send Mail to this Address (Y/N): _____

Change/Addition of Other Addressee:

Name: _____

_____

City: _____

State: _____

ZIP: _____ + _____

Country: _____

(for foreign address only)

Relationship: _____ 1=Custodial Parent

Enter one of the 6 listed codes. 2=Trustee

3=Power of Attorney

4=Legal Guardian

5=Mailing Address

6=In Care Of (C/O)

Send Mail to this Address (Y/N): _____

Dependent Address Change:

Effective Date of Change: _____/_____/_____

Residential Address (Other than Member's)

_____

_____

City: _____

State: _____

ZIP: _____ + _____

Resident county: _____

Country: _____

(for foreign address only)

Send Mail to this Address (Y/N): _____

Change/Addition of Other Addressee (custodial parent, guardian, etc.)

Name: _____

_____

City: _____

State: _____

ZIP: _____ + _____

Country: _____

(for foreign address only)

Relationship: _____ 1=Custodial Parent

Enter one of the 6 listed codes. 2=Trustee

3=Power of Attorney

4=Legal Guardian

5=Mailing Address

6=In Care Of (C/O)

Send Mail to this Address (Y/N): _____

INSTRUCTIONS FOR COMPLETING THE MEMBER AND/OR DEPENDENT ADDRESS CHANGE FORM

- This form is used to change the member's address on both the Membership and FSA Systems. The form also is used to change the dependent's address on the Membership System.

- Enter a dependent's residential address only if the address is different than the members.

Complete the areas labeled Agency Name, Organizational Processing Code, Member Name, and Member Social Security Number. The member should sign the form. If the member cannot come into the office to sign the form, attach a memo/letter from the member with his/her signature and date they are requesting the change. ***GIR signature and date is required.***

Other Addressee: In some cases, a member or dependent may need to record the name and address of another person who may be responsible for their insurance, such as in the case of a trustee, custodial parent or legal guardian. The 'Other Addressee' portion of this form is to be used for this purpose.

Send Mail to this Address (Y/N): If a 'Y' is entered in this field, mail will be sent to this address. It is possible to have mail sent to multiple addresses, such as in the case of members who have both a residential address and an 'Other Addressee'; however, in most cases, the 'Mail To' indicator would be set to 'Y' for only one of the addresses on file.

Foreign Addresses: When entering a foreign address on the Member or Dependent Address screen, enter 104 in the county code field. Enter either a Country Code (the 3-digit country codes can be found in Appendix H – System Codes section of the Group Insurance Manual) or the Country Name. When a foreign country is entered, the zip+4 field becomes unprotected and allows the foreign postal code to be entered.

Refer to Section 12.29, Address Format, in the Group Insurance Manual for further explanation of entering address information into the Membership System.

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

STATE OF ILLINOIS
GROUP LIFE INSURANCE PROGRAM
BENEFICIARY DESIGNATION

MEMBERS MAY DESIGNATE PRIMARY CONTINGENT BENEFICIARIES. **Beneficiaries will receive equal shares, unless specific percentages are indicated.** Contingent beneficiaries become effective only when all primary beneficiaries have died prior to the member's death. A beneficiary may be a person, trust, estate, or other legal entity. You may designate as many primary or contingent beneficiaries as you feel necessary. If you need more space, please copy this sheet or attach another form CMS-617.

Beneficiary designations may be changed by the member at any time by submitting a new form.

If a beneficiary has not been designated, or all designated beneficiaries have died prior to the member's death, any proceeds payable shall be paid according to the Facility of Payment section of the State of Illinois Group Life Insurance Program book. Call Minnesota Life at 888-202-5525 if you would like assistance completing this form.

FIRST NAME MIDDLE INITIAL LAST NAME	DATE OF BIRTH (Mo/Day/Yr)	SOCIAL SECURITY NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
DATE EMPLOYED	MEMBER STATUS (Check all that apply) ☐ FULL TIME EMPLOYEE ☐ PART TIME EMPLOYEE ☐ IMMEDIATE ANNUITANT ☐ DEFERRED ANNUITANT ☐ SURVIVOR		

Transaction Type

☐ Initial Designation ☐ Change of Beneficiary ☐ Change of Address of Beneficiary

Primary *or* Contingent Percent

☐ P ☐ C ______ % Last Name First Name MI Relationship Date of Birth
Street City, State, Zip Social Security Number

☐ P ☐ C ______ % Last Name First Name MI Relationship Date of Birth
Street City, State, Zip Social Security Number

☐ P ☐ C ______ % Last Name First Name MI Relationship Date of Birth
Street City, State, Zip Social Security Number

☐ P ☐ C ______ % Last Name First Name MI Relationship Date of Birth
Street City, State, Zip Social Security Number

☐ P ☐ C ______ % Last Name First Name MI Relationship Date of Birth
Street City, State, Zip Social Security Number

☐ P ☐ C ______ % Last Name First Name MI Relationship Date of Birth
Street City, State, Zip Social Security Number

I hereby designate the above-named beneficiary(ies). I reserve the right, without consent of the beneficiary, to further change the beneficiary subject to any statutory restrictions. The above designation supersedes all prior designations of beneficiaries I have made.

Form must be signed and filed with Minnesota Life Insurance Company to validate designation.
Minnesota Life Insurance Company ▪ 1 North Old Capitol Plaza #305 ▪ Springfield, IL 62701

MEMBER SIGNATURE	DAYTIME TELEPHONE NUMBER	EVENING TELEPHONE NUMBER	DATE
X	( )	( )	

COORDINATION OF BENEFITS WORKSHEET

If you, or any of your dependents who are covered under any State of Illinois health plan, are covered under any other health plan(s), you must provide this information to your Group Insurance Representative to ensure health claims are correctly processed (examples include non-state group health plans, Medicare and Medicaid).

You must complete Section A and Section C below. If you have other insurance, you must also complete Section B **and** provide a copy of the insurance identification card from the other coverage. You must return the completed COB Worksheet to your Group Insurance Representative/Preparer.

SECTION A

Member Name: _____ Social Security #: _____

☐ I and/or my dependents do NOT have other group health insurance coverage.

☐ I and/or my dependents DO have other group health insurance coverage (you must complete Section B indicating the other coverage). **YOU MUST COMPLETE A SEPARATE FORM FOR EACH INSURANCE COMPANY.**

SECTION B

Insurance Company Name: _____

Policy Holder Name: _____

Identification Number: _____ Group Number: _____

Effective Date: _____ Policy Type: Medical _____ Dental _____

Covered Persons	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

SECTION C

It is my responsibility to ensure that accurate information is maintained and kept updated regarding my other health/dental insurance. If other coverage is added or terminated for any individuals covered under my State Employees' Group Insurance Program, I must notify the Group Insurance Representative immediately.

I certify the above information is accurate.

Member Signature: _____ Date: _____

THIS FORM MUST BE RETURNED TO THE GROUP INSURANCE REPRESENTATIVE AT YOUR AGENCY TO EXPEDITE CLAIM PROCESSING.

Agency Name:_____ Org. Proc. Code: _____

Member Name: _____ Member SSN: _____

Dependent Name: _____ Dependent SSN: _____

Mbr signature _____ Date: _____

GIR Signature: _____ Date: _____

DEPENDENT CHANGE FORM

Check One: Change ☐ Termination ☐ Correction ☐

DEPENDENT BIOGRAPHICAL: **Effective Date of Change:** ___/___/____

Dependent. SSN	Temp SSN (Y/N)	Last Name	First Name	Middle Name
_____-____-_____	_____	_____	_____	_____

Birthdate	Sex (M/F)	Retirement Date	Medicare Number
___/ ___/ ____	_____	____/ ___/ _____	_____

Medicare Status Code	Part A Begin Date	Free Part A (Y/N)	Part B Begin Date
_____	____/ ____/ _____	_____	____/ ___/ _____

DEPENDENT GROUP: **Effective Date of Change:** ___/___/____

Type Dependent - Check One**:** ____ Active (type 10) ____ Terminated (80) ____ Term Reason Code

Relationship Code: _____

Recertification Date: Annual: ___/___/____ 19th Birthdate: ___/___/____ 23rd Birthdate: ___/___/____

Note: Annual date must be 09/01 of current year; 19th and 23rd Birthdate must be dependent's birth month and day and current year.

DEPENDENT PLANS: **Effective Date of Change:** ___/___/____

Plan	Actv/Term A/T	Waiver Reason	Pre-exist. Months	Carrier Code	Carrier Chg. Reason	PCP# If Appl.
Health	___	____	_____	___	_____	_____
Dental	___	____	_____	___	_____	_____
Life	___	____	N/A	___	Life Certificate Approval Date: ___/___/____	

COORDINATION OF BENEFITS: When adding a dependent to the insurance coverage, the member must complete a Coordination of Benefits form certifying whether or not the dependent has other health/dental coverage.

INSTRUCTIONS FOR COMPLETING THE DEPENDENT FORM

This form is used for changes, terminations and corrections **only**. Check the appropriate box under the title of the form to indicate the type of transaction being submitted, i.e., change, termination or correction.

Complete the areas labeled Agency Name, Organizational Processing Code, Member name, Member Social Security Number. The member should sign the form. If the member cannot come into the office to sign the form, attach a memo/letter from the member with his/her signature and date requesting the changes. ***GIR signature and date is required.***

Dependent Biographical Section:

Enter the Dependent's SSN. Enter 'Yes' (Y) if the SSN # is temporary; enter 'No' (N) if the SSN# is not temporary.

Complete any other information that may be changing: Please note the following:

If the dependent is retired, enter the date of retirement.

Medicare status codes are listed in Appendix H of the Group Insurance Manual.

If the member is enrolled in Medicare, enter the information requested for Part A and Part B, as well as the Medicare number.

Dependent Group Section:

Type Dependent: If the type of dependent is changing, indicate the dependent type, either active or terminated. Dependent types are '10' for dependents of active members and '80' for terminated dependents. If the dependent's coverage is being terminated, enter the termination reason code, found in Appendix H, page 7 of the Group Insurance Manual.

Relationship Code: Enter the dependent relationship code. For example, if the relationship is changing from son to student, enter the relationship code for student. Relationship codes are found in Appendix H of the Group Insurance Manual.

Dependent Plans Section:

Enter the information that is changing. Please note the following:

The dependent must have the same health and dental plans as the member. For example, if the member elects health plan A, the dependent must be enrolled in health plan A.

Health Carrier Codes are listed in the Benefit Choice Booklet. Dental and Life Carrier Codes are listed in Appendix H of the Group Insurance Manual.

PCP# for managed care providers are located in the individual provider listings.

CMS

ILLINOIS
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

STATE OF ILLINOIS GROUP INSURANCE PROGRAM

DEPENDENT COVERAGE CERTIFICATION STATEMENT

EMPLOYEE NAME:_____ **MBR. SSN:** _____

DEPENDENT NAME:_____ **DEP. SSN:** _____

CERTIFICATION EFF. DATE: _____

I certify that the above dependent meets ALL of the qualifications for continued coverage in the dependent category checked below. I have attached the required documentation as stated on the back of this Statement.

Dependent Category ***(Check One)***	**Qualification**
___ Student	Dependent at least age 19 but not yet 23, **and** (1) enrolled as a full-time student in an accredited school, **and** (2) financially dependent upon me, **and** (3) eligible to be claimed as my dependent for income tax purposes.
___ Handicapped	Age 19 or older, **and** (1) continuously disabled from a cause originating prior to age 19, **and** (2) financially dependent upon me, **and** (3) eligible to be claimed as my dependent for income tax purposes.
___ OTHER: Mother, Father, Son, Daughter, Brother Sister, Niece, Nephew Grandparent	Dependent is (1) financially dependent upon me, **and** (2) eligible to be claimed as my dependent for income tax purposes, **and** (3) has either: (3a) received an organ transplant after June 30, 2000, **or** (3b) has been continuously enrolled as a dependent in the State of Illinois Insurance Program (or CNA for university staff) with no break in coverage prior to February 11, 1983.

Please contact your insurance representative for questions regarding continuous coverage or transplant eligibility.
Note: Dependents enrolled in the 'Other' category are not eligible for life insurance coverage.

___ **Terminate Dependent**: My dependent no longer meets the eligibility criteria. By checking the 'Terminate Dependent' line and signing below, I am authorizing the termination of my dependent's coverage.

I understand that it is my responsibility to notify my agency Insurance Representative when and if the above person ceases to meet the qualifications as stated above. I acknowledge and understand that failure to notify the State of changes in my dependent's status will result in termination of coverage retroactive to the last eligible date, recovery of all claim payments and possible forfeiture of premiums paid.

_____ _____

(Member's Signature) (Date) (Insurance Rep's Signature) (Date)

RETURN THIS FORM TO YOUR INSURANCE REPRESENTATIVE

201 E. Madison, Suite 2B, P.O. Box 19208, Springfield, IL, 62794-9208

Qualifying Criteria and Required Documentation
For Student, Handicapped or 'Other' Dependent Categories

STUDENT: **Qualifying Criteria**

a. Unmarried child age 19 through age 22, **and**

b. Enrolled as a full-time student in an accredited school, **and**

c. Financially dependent upon the member, **and**

d. Eligible to be claimed as a dependent for income tax purposes by the member

Required Documentation

1. Verification of enrollment as a full-time student *, **and**

2. Dependent Coverage Certification Statement

** Examples of documentation include: letter from the Office of the School Registrar, tuition bill marked "paid", copy of enrollment from the university's web-site, abbreviated transcript, copy of grant award or tuition waiver, itemized statement of account.* **Full-time student status must be indicated on the document submitted.**

Note: If your dependent no longer qualifies as a 'Student', he/she may qualify as 'Handicapped' or 'Other' as follows:

HANDICAPPED: **Qualifying Criteria**

a. Unmarried child age 19 or older who is mentally or physically handicapped, **and**

b. Continuously disabled from a cause originating prior to age 19, **and**

c. Financially dependent upon the member, **and**

d. Eligible to be claimed as a dependent for income tax purposes by the member

Required Documentation

1. A diagnosis from a MD with an ICD-9 diagnosis code, **and**

2. Letter from the doctor detailing the dependent's limitations, capabilities and onset of condition, **and**

3. Statement from the Social Security Administration with the Social Security disability determination, if applicable, **and**

4. Dependent Coverage Certification Statement

OTHER: **Qualifying Criteria**

a. Financially dependent upon the member, **and**

b. Eligible to be claimed as a dependent for income tax purposes by the member, **and** has either:
   (1) received an organ transplant after June 30, 2000, or has
   (2) been continuously enrolled as a dependent in the State of Illinois Insurance Program (or CNA for university staff) with no break in coverage prior to February 11, 1983.

Required Documentation

1. Dependent Coverage Certification Statement

If you have any questions regarding dependent eligibility or the information provided above, please contact your agency Insurance Representative or CMS Group Insurance Division at (217) 558-4978 or (800) 442-1300.

CMS

ILLINOIS
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

WAIVING ANNUITANT GROUP INSURANCE COVERAGE
NOTIFICATION AND ELECTION FORM

In accordance with Public Act 93-553, this Notification and Election Form is provided to State of Illinois Retirement Systems Annuitants to inform them of the consequences of electing to participate in the State Employees Group Insurance Program as a *Dependent*, and the conditions and procedures for re-enrolling at a later time as an eligible *Member*. By completing this waiver and signing below, a person eligible to participate in the Group Insurance Program as an Annuitant, can elect to waive health, dental and vision Group Insurance coverage, and instead participate as a dependent of their spouse.

Dependent Name: _____	**Spouse Name: _____**
Dependent SSN: _____	**Spouse SSN: _____**
Daytime Phone #: _____	**Daytime Phone #: _____**

I fully understand and certify to the following:

1. In electing to participate in the health plan as a dependent of my eligible Spouse, I acknowledge that I am waiving health, dental and vision coverage as an Annuitant.

2. I will be enrolled as an Annuitant with Basic Life insurance coverage. If I currently have optional life coverage, I have the option of continuing that coverage. Statement of Health approval will be required to obtain additional optional life insurance coverage.

3. I cannot be enrolled in Spouse Life coverage as a dependent of my eligible spouse.

4. Re-enrollment in the health, dental and vision Program as an eligible Member can be done only during the annual Benefit Choice period (May 1-31 of each year) or within 60 days of a qualifying Change in Status. If I wish to re-enroll, I must contact my Group Insurance Representative to complete and sign the Initial Enrollment form (CMS-310), and submit the required back-up documentation.

Dependent Signature: _____ Date: _____

GIR/P USE ONLY

Effective date Dependent is/was added to Spouse's H/D/V plan: _____

Effective Date of Dependent Annuity: _____

Comments:_____

_____

_____ _____
Group Insurance Representative Signature/Date Phone #

_____ _____
Agency Name Organizational Processing Code

AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

Department of Central Management Services, Bureau of Benefits

I, _____ _____
(Print First and Last Name) (Membership Number)

hereby authorize _____ to disclose protected health information related to
(Entity, Name, Plan Administrator, etc.)
services provided in connection with my medical treatment.

This medical information may be disclosed to:

Personnel within the Bureau of Benefits, Benefit Plan Administrators with which the department contracts and other individuals (specify, if applicable) _____ assisting me with this request.

Describe the information to be used or disclosed.

_____

Indicate the reason for the release or request of information:

At the Request of the Individual or Personal Representative

Other: _____

I understand that if I refuse to sign this authorization, the above-described health information will not be disclosed except as provided by law.

I understand that:

- Payment, enrollment or eligibility for benefits for my health care will not be affected if I do not sign this form.
- I may revoke this authorization at any time by written notification to the entity listed above. My revocation will have no effect on information that has been released under this authorization prior to receipt of my intent to revoke such authorization.
- Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.
- I am entitled to a copy of this authorization upon signature.

This authorization expires on _____.
(Date)

Signature: _____ Date Signed:_____

If a personal representative executes this form, that representative warrants that he or she has authority to sign this form on the basis of _____.
(Parent, Guardian, Power of Attorney, or other Authorized Representative)

_____ _____
(Signature) (Date)

Agency Name: _____
Member SSN: _____-_____-_____

Department of Central Management Services
State of Illinois
Group Insurance Initial Enrollment Form

MEMBER BIOGRAPHICAL INFORMATION: (Please print or type)

Member SSN:_____-____-_____ GI Proc Org:_____ _____ _____ Eff. Date of Add: _____-_____-_____

Name:_____ _____ _____
Last First Middle

Marital Status (S/M): _____ Handicapped (Y/N): _____ Birthdate (mm/dd/ccyy): ____-____-_____

Sex: (M/F): ____ Phone Number: Home (_____) _____-_____ Work (_____) _____-_____

Medicare Status: (check one)

1	Non-Medicare	☐	If Medicare is 2, 4, or 5, complete the following:
2	Medicare Eligible	☐	Part A (Begin Date) _____ - _____ - _____
3 *	Medicare Ineligible 65+	☐	Part B (Begin Date) _____ - _____ - _____
4	Medicare disability	☐	Part A Free (Y) ☐ (N) ☐
5	End Stage Renal	☐	Part A Free (Y) ☐ (N) ☐

* If the medicare status is 'Medicare Ineligible 65+' (Option 3), the enrollment form must be sent to the GID Medicare COB Unit for processing.

If the member has a power of attorney, legal guardian, or trustee, please complete the Other Addressee information, if different than member's.

Member Residential Address

_____
_____
City: _____
State: _____
ZIP: _____ + _____
Resident county: _____
Country: _____
(for foreign address only)
Send Mail to this Address (Y/N): _____

Other Addressee Information

Name/Org: _____
_____
_____
City: _____
State: _____
ZIP: _____ + _____
Country: _____
(for foreign address only)
Type of Address: _____
Send Mail to this Address (Y/N): _____

MEMBER GROUP:

Type Enrollee:_____ _____ Full Time/Part Time % _____
Deduction Frequency: Semi Monthly/Monthly (S/M) _____

Survivors Only:

SSN of deceased member:_____-_____-_____ Relationship to Deceased Member (S/C/P) ____

Agency Name: _____
Member SSN: _____-_____-_____

Agency Information:
Payroll Agency:_____ Work County:_____
Distribution Code:_____

MEMBER PLANS (Health/Dental/Life):
Health:

Actv/Term A/T	Waiver Reason	Pre-existing Months Appl.	Carrier Code	PCP# (If Applicable)	Estimated Annual Salary

Dental:
- ☐ I elect not to participate in the Dental Plan. (GIR/P: Enter dental carrier code 'DD' on Membership)
- ☐ Active (GIR/P: Enter Quality Care Carrier Code 'D6' on Membership)
- ☐ Terminated: Enter waiver reason _____

Life:
Active/Term (A/T):_____ Waiver reason, if applicable:_____

Member Basic Life Units	Optional 1 – 8 times	AD&D (N/B/C) (none/basic/combined)	Survivors Only Opt. Life (Y/N)	Spouse Life (Y/N)	Child Life (Y/N)

COORDINATION OF BENEFITS: Upon electing to participate in the Group Insurance Program, the member must complete a Coordination of Benefits form for themselves and each dependent certifying whether or not they have other health/dental coverage.

I authorize prevailing premiums (if any) to be deducted from my pay or annuity for those coverages I have selected. This authorization is to remain in effect until I provide written notice to the contrary. The statement and answers contained in this application are complete and true. I agree to abide by all appropriate rules. I agree to furnish any additional information if requested.

My signature confirms that I understand all above options selected. At all times this form must be signed by the member.

Required Member Signature:_____ Date:_____

I have reviewed and explained all options available to the above member. This form must be completed by the agency personnel and reviewed with the member. This form is not to be completed by the member.

Group Insurance Representative Signature:_____ Date:_____

Agency Name: _____
Member SSN: _____-_____-_____
Dependent _____ of _____

Department of Central Management Services
State of Illinois
Group Insurance Initial Enrollment Form
DEPENDENT INFORMATION

DEPENDENT BIOGRAPHICAL: (Please print or type) Eff. Date of Add:_____-____-_____

SSN	Temp (Y/N)	Last Name	First Name	Middle Name
___ - ___ - ___	___	_____	_____	_____

Birthdate	Birth Sequence # *	Sex (M/F)	Retirement Date
___ - ___ - ___	_____	_____	___ - ___ - ___

* Only enter a Birth Sequence number when the dependent is one of a multiple birth on the same date (i.e., first born – 1, second born – 2, etc., born on the same day, month and year).

Medicare Status **	Part A Begin Date	Free Part A (Y/N)	Part B Begin Date
___	___ - ___ - ___	___	___ - ___ - ___

** If the medicare status is 'Medicare Ineligible 65+' (Option 3), the enrollment form must be sent to the GID Medicare COB Unit for processing.

If a dependent is to receive mail at an address other than the member's, please indicate below:

Dependent Address (Other than Member's)
(e.g., college campus address)
_____
_____
City: _____
State: _____
ZIP: _____ + _____
Resident county: _____
Country: _____
(for foreign address only)
Send Mail to this Address (Y/N): _____

Dep. Other Addressee (custodial parent, guardian, etc.)
Name/Org: _____
_____
_____
City: _____
State: _____
ZIP: _____ + _____
Country: _____
(for foreign address only)
Type of Address: _____
Send Mail to this Address (Y/N): _____

Type Dependent:
Relationship Code *: _____ See GI Manual, Appendix H, page 6 for listing of relationship codes.
* Dependents coded as Student, Handicapped, or "Other" must have backup documentation (refer to the Group Insurance Manual for documentation requirements). Dependents must be enrolled with the same health and dental carrier as the member.

Health
Status (circle one) Active or Terminated
Carrier Code _____
6-digit PCP# (if managed care) _____
Pre-Existing Months _____

Dental
Active / Term

Dependent Life
Yes / No

I understand that I must provide documentation as proof of my relationship to my dependents (i.e., children/spouse).

Required Member Signature:_____ **Date:**_____

Agency Name: _____
Member SSN: _____-_____-_____
Dependent _____ of _____

Department of Central Management Services
State of Illinois
Group Insurance Initial Enrollment Form
DEPENDENT INFORMATION

DEPENDENT BIOGRAPHICAL: (Please print or type) Eff. Date of Add:_____-____-_____

SSN	Temp (Y/N)	Last Name	First Name	Middle Name
___ - ___ - ___	___	_____	_____	_____

Birthdate	Birth Sequence # *	Sex (M/F)	Retirement Date
___ - ___ - ___	_____	_____	_____ - _____ - _____

* Only enter a Birth Sequence number when the dependent is one of a multiple birth on the same date (i.e., first born – 1, second born – 2, etc., born on the same day, month and year).

Medicare Status **	Part A Begin Date	Free Part A (Y/N)	Part B Begin Date
___	___ - ___ - ___	___	_____ - _____ - _____

** If the medicare status is 'Medicare Ineligible 65+' (Option 3), the enrollment form must be sent to the GID Medicare COB Unit for processing.

If a dependent is to receive mail at an address other than the member's, please indicate below:

Dependent Address (Other than Member's)
(e.g., college campus address)
_____
_____
City: _____
State: _____
ZIP: _____ + _____
Resident county: _____
Country: _____
(for foreign address only)
Send Mail to this Address (Y/N): _____

Dep. Other Addressee (custodial parent, guardian, etc.)
Name/Org: _____
_____
_____
City: _____
State: _____
ZIP: _____ + _____
Country: _____
(for foreign address only)
Type of Address: _____
Send Mail to this Address (Y/N): _____

Type Dependent:
Relationship Code *: _____ See GI Manual, Appendix H, page 6 for listing of relationship codes.
* Dependents coded as Student, Handicapped, or "Other" must have backup documentation (refer to the Group Insurance Manual for documentation requirements). Dependents must be enrolled with the same health and dental carrier as the member.

Health
Status (circle one) Active or Terminated
Carrier Code _____
6-digit PCP# (if managed care) _____
Pre-Existing Months _____

Dental
Active / Term

Dependent Life
Yes / No

I understand that I must provide documentation as proof of my relationship to my dependents (i.e., children/spouse).

Required Member Signature:_____ **Date:**_____

LEAVE OF ABSENCE

Continuation or Waiver of Coverage

For GIR Use Only

Section A: Employee Information

Employee Name: _____ Social Security Number: _____

Leave Type/Subtype Code _____ PT %: _____ Effective Date: _____

Section B: Premium Calculation

Use the Membership System Deduction Calculation Screen - 5C to calculate the monthly premiums of the member.

Member Health & Dental: _____ Member and Dependent Life: _____

Dependent Health & Dental: _____

Section C: Your Rights & Responsibilities

It is your right to:

- Continue or waive your group insurance coverage for the period you will be on leave of absence.
- Have your prior health/dental coverage elections reinstated when you return to work if you waived coverage.
- Become a dependent of your State employed spouse if …
  - you are responsible for 100% of the State and member portions of insurance coverage, **and**
  - elect to waive all of that coverage (including Basic Life).

It is your responsibility to:

- Pay your elected premiums timely.
- Notify your Personnel Office and *Group Insurance Representative/Preparer* immediately when you…
  - change your address
  - return to work from a leave of absence

Section D: Billing Procedure

Billing statements will be sent to you on a monthly basis by CMS' Premium Collection Unit. Payment must be received by the due date indicated on the statement. If payment is not received by the due date, coverage will be terminated retroactively to the last paid-through date.

Section E: Election & Certification

I understand the above and (check one):

☐ I want to continue all of my insurance and agree to pay the premiums when billed.

☐ I want to waive coverage for myself and my dependents. I understand my premium-free Basic Life will remain in effect unless I am on a personal/general leave of absence.

☐ I want to waive my health and dental coverage, but continue my:
- ☐ Basic Life (this option only applies if you are going on a personal/general leave of absence)
- ☐ Optional Life

☐ I want to continue my health and dental coverage, but waive my:
- ☐ Dependent Health and Dental
- ☐ Optional Life (includes Member Optional Life, AD&D, Spouse Life and Child Life)

I have read, understand and agree to the Rights and Responsibilities as indicated in sections C and D above.

Member Signature _____ Date _____

GIR/GIP Signature _____ Date _____

Agency Name:_____ Org. Proc. Code: _____

Member Name: _____ Member SSN: _____

Member Signature _____ Date: _____

GIR Signature: _____ Date: _____

MEMBER CHANGE FORM

Check One: Change ☐ Termination ☐ Correction ☐

MEMBER BIOGRAPHICAL INFORMATION: **Effective Date of Change:** ___/___/____

Member SSN: ____-___-_____ Previous SSN: ____-___-_____

SSN Change: ____ - ___ - _____

Name_____ _____ _____

Last First Middle

Marital Status: (S/M) ___ Birth date (mm/dd/ccyy): ___/___/____ Sex: (M/F): ___

Date of Death: ___/___/____

Medicare Status: ____ Part A (Begin Date): ___/___/____ Part A Free (Y/N): ___

Medicare Number: _____ Part B (Begin Date): ___/___/____

MEMBER GROUP INFORMATION: **Effective Date of Change:** ___/___/____

Type Enrollee: __ __ __ __ Full Time/Part Time %: _____

Deduction Frequency - Semi-Monthly / Monthly (S/M): ___

Qualifying Change Reason: ___ Request Date: ____/____/_____

Org. Proc. Code Change: _____

Cusas Work Agency:_____ Work County:_____ Distribution Code:_____

MEMBER PLAN INFORMATION: **Effective Date of Change:** ___/___/____

Health/Dental:

Plan	Actv/Term (A/T)	Waiver Reason	Pre-exist. Months	Carrier Code	Chg. Reason	PCP# If Appl.	Estimated Annual Salary
Health	___	____	_____	____	_____	_____	$_____
Dental	___	____	_____	____	_____	__n/a__	

COORDINATION OF BENEFITS: When adding a dependent to the insurance coverage, the member must complete a Coordination of Benefits form certifying whether or not the dependent has other health/dental coverage.

Life Plan: **Effective Date of Change**: ___/___/____

Active/Term (A/T):___ Waiver Reason (if applicable):____ Certificate Approval Date: ___/___/____

Member Basic Life Units	Optional Life 1 – 8 X	AD & D (N/B/C) (None/Basic/Combined)	Survivor's Only Opt. Life (Y/N)	Spouse Life (Y/N)	Child Life (Y/N)
_____	_____	_____	_____	_____	_____

INSTRUCTIONS FOR COMPLETING THE MEMBER CHANGE FORM

This form is used for changes, terminations and corrections **only**. Check the appropriate box under the title of the form to indicate the type of transaction being submitted, i.e., change, termination or correction.

Complete the areas labeled Agency Name, Organizational processing code, Member name and Member Social Security Number. The member should sign the form. If the member cannot come into the office to sign this form, attach a memo/letter from the member with his/her signature and date requesting the changes. ***GIR signature and date is required.***

Member Biographical Section:

Enter the Member SSN. Enter 'Yes' (Y) if the SSN # is temporary; enter 'No' (N) if the SSN# is not temporary. If the member is on the Membership System under a previous SSN, enter this number in the 'Previous SSN' field. If you are requesting a change in SSN, indicate the change in the 'SSN Change' field and attach a copy of the member's Social Security card.

Complete any other information that may be changing: Please note the following:

Medicare status codes are listed in Appendix H of the Group Insurance Manual.

If the member is enrolled in Medicare, enter the information requested for Part A and Part B, as well as the Medicare number. Attach a copy of the Member's Medicare card.

Member Group Section: Enter the information that is changing. Please note the following:

Type enrollee codes can be found in Appendix H of the Group Insurance Manual.

If you are transferring a member from a monthly-paid Agency to a semi monthly-paid agency, the transfer must be effective the first day of the month to avoid discrepancies (the Membership System will not allow a change for any date other than the 1st for this kind of transaction).

Qualifying Change Reason codes can be found in Appendix H of the Group Insurance Manual.

Member Plan Section: Enter the information that is changing. Please note the following:

Waiver reasons are located in Appendix H of the Group Insurance Manual.

Pre-existing months indicate how long the pre-existing condition applies to this member.

Health Carrier Codes are listed in the Benefit Choice Booklet. Dental and Life Carrier Codes are listed in Appendix H of the Group Insurance Manual.

Carrier change reason codes are listed in Appendix H of the Group Insurance Manual.

PCP# for managed care providers are located in the individual provider listings.

Member Basic Life Units are derived by dividing the member's annual base salary by 100 and rounding up. This information will change if the member experiences an increase or a decrease in base salary. The effective date should be the actual date of change; **not the pay period end date.**

Health certificates for increasing life insurance coverage must be attached to this form.

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

OPT OUT & OPT IN Election Certificate

Section A: OPT OUT (See Section B to Opt In)

In accordance with Public Act 92-0600, State of Illinois full-time employees, retirees/annuitants and survivors may elect not to participate in the health, dental and vision coverage of the State of Illinois Group Insurance Program (Program). Enrolled dependents of individuals electing to opt out will be terminated on the same date as the Member.

Member Name:_____ Member SSN:_____

I fully understand and certify the following:

1. The election to opt out of the Program is entirely voluntary. If I elect to opt out, any dependent coverage will also be terminated. The State of Illinois is not responsible for any expenses incurred, for myself or my dependents, on or after my termination date. Furthermore, my covered dependents and I are not eligible for COBRA continuation coverage.
2. I must complete Section A of the Opt Out & Opt In Election Certificate and furnish proof of enrollment in another health benefit plan, either comprehensive major medical or comprehensive managed care, from a source other than the Illinois Department of Central Management Services (Department) including the Local Government Health Plan, Teachers' Retirement Insurance Program or College Insurance Program before my coverage will be terminated. My Program coverage will not be terminated until other eligible coverage is in effect, appropriate documentation has been submitted and such documentation has been approved by the Department. The effective date of opt out is at the discretion of the Department and must comply with Program requirements regarding opt out.
3. I may opt out of the Program only during the annual Benefit Choice period or within 60 days of an eligible Qualifying Change in Status.
4. If my spouse is a Member of any plan administered by the Department including the State of Illinois Group Insurance Program, Local Government Health Plan, Teachers' Retirement Insurance Program or College Insurance Program, I may not enroll as a dependent of my spouse in that plan.
5. If I elect to opt out of the Program, I will continue to be enrolled in the state-paid basic life insurance plan. I understand I am eligible to participate in the optional life insurance plan.
6. At a later date, if I wish to re-enroll in one of the health plans administered by the Department, I understand pre-existing condition limitations may apply if I am unable to provide a Certificate of Creditable Coverage from my previous insurance carrier that reflects that there has been no break in coverage greater than 63-days.
7. To the best of my knowledge, the opt out documentation furnished to substantiate coverage in another health benefit plan is accurate and the policy is currently (or will be, prior to my termination) in force.

Member Signature:_____ Date: _____/_____/_____

Please send this completed form with proof of other coverage to your agency Group Insurance Representative (GIR). Employees electing to opt out of the Program during the annual Benefit Choice Period must also complete and submit the Benefit Choice Election form, which is available through your agency GIR.

GIR/P Use Only

Proof of comprehensive coverage attached? ☐

Check the appropriate Opt Out eligibility period:

☐ Initial Enrollment (attach completed Initial Enrollment form, CMS-310) ☐ Benefit Choice

☐ Qualifying Change in Status*; Reason Code:_____

**** Valid Qualifying Changes in Status and corresponding Reason Codes are:***

Marriage (32)	Return from/Entering into Non-pay Status (63)
Change from PT to FT (63)	Spouse now provided with Group Insurance coverage (46)
Spouse Gains Employment (62)	Medicare or Medicaid Eligibility Gained (64)
Retirement (63)	Coordination of Spouse's Election Period (47)
Member Becomes Eligible for Non-State Group Insurance Coverage (65)	

_____ _____

Group Insurance Representative Signature/Date Telephone Number

_____ _____

Agency Name Organizational Processing Code

GIR must send completed form and documentation to the CMS Group Insurance Division | **For questions call:** (217) 558-4978

CMS Only

Coverage documentation submitted: ☐ Approved ☐ Denied

Opt Out Effective Date: _____ **GID Signature/Date**: _____

Section B: OPT IN (See Section A to Opt Out)

State of Illinois full-time employees, retirees/annuitants and survivors who have previously elected not to participate in the health, dental and vision coverage of the State of Illinois Group Insurance Program (Program), may elect to opt back into Program only upon experiencing a qualifying change in status or during the annual Benefit Choice Period.

Member Name:_____ Member SSN:_____

I fully understand and certify the following:

1. I may opt into the Program only during the annual Benefit Choice period or within 60 days of an eligible Qualifying Change in Status.
2. I must complete Section B of the Opt Out & Opt In Election Certificate and furnish proof of a qualifying change in status (unless election is made during the Benefit Choice Period) before my coverage will be activated. My Program coverage will not be activated until appropriate documentation has been submitted and such documentation has been approved by the Department. The effective date of coverage is at the discretion of the Department and must comply with Program requirements regarding opt in.
3. If I elect to opt into the Program, I will continue to be enrolled in the state-paid basic life insurance plan. I understand I may be eligible to apply for optional life coverage if my qualifying change in status is consistent with the optional life coverage being requested.
4. Upon re-enrolling in one of the health plans administered by the Department, I understand pre-existing condition limitations may apply if I am unable to provide a Certificate of Creditable Coverage with no break in coverage of more than 63-days from my previous insurance carrier.
5. Upon re-enrolling in one of the health plans administered by the Department, I understand that I can elect not to participate in the dental plan and remain enrolled in health and vision. If I elect not to participate in dental, I will not be able to re-enroll in the dental plan until the next Annual Benefit Choice period.

Member Signature:_____ Date: _____/_____/_____

Employees electing to opt back into the Program during the Benefit Choice Period must complete and submit a Benefit Choice Election form (CMS-350). Employees electing to opt back into the Program due to a Qualifying Change in Status must complete and submit an Initial Enrollment form (CMS-310). Both forms are available through your agency GIR.

Please submit this completed form and appropriate documentation (e.g., proof of loss of other coverage, documentation required to add dependent coverage), along with the Benefit Choice Election form or Initial Enrollment form to your agency Group Insurance Representative (GIR).

GIR/P Use Only

Check the appropriate Opt In eligibility period:

☐ Benefit Choice (attach completed Benefit Choice Election form, CMS-350)

☐ Qualifying Change in Status*: Reason Code:_____ (attach completed Initial Enrollment form, CMS-310)

Proof of Qualifying Change in Status attached? ☐

**** Valid Qualifying Changes in Status and corresponding Reason Codes are:***

Divorce/Legal Separation/Annulment (60)	Marriage (32)
Medicaid or Medicare Eligibility Loss (64)	Retirement (63)
Spouse Loses Employment (33)	Death of Spouse (61)
Coordination of Spouses Annual Election Period (47)	Member Returns to Work from Non-Pay Status (63)

Spouse Loses Eligibility for Group Insurance Coverage (34)
Premium Increase 30% or Greater: Employees Non-State Health Insurance (45)
Premium of Spouse's Employer Increases 30% or Greater, or Coverage Significantly Decreases (45)
Member Loses Eligibility of Non-State Group Insurance Coverage (for reason other than non-payment) (68)

_____ _____
Group Insurance Representative Signature/Date Telephone Number

_____ _____
Agency Name Organizational Processing Code

GIR must send completed form and documentation to the CMS Group Insurance Division | **For questions call:** (217) 558-4978

CMS Only

Coverage documentation submitted: ☐ Approved ☐ Denied

Opt In Effective Date: _____ **GID Signature/Date**: _____

SAMPLE
"ON AGENCY LETTERHEAD"

OTHER DEPENDENT ADDRESS INFORMATION WORKSHEET

Member Name: _____ Member SSN: _____

Dependent Name: _____ Dependent SSN: _____

Dependent Residential Address: If a covered dependent resides at an address that is different from the member address, e.g., student away at college, indicate the address in the section below.

USA Address:

Street: _____

_____

C/S/Z: _____ _____

Foreign Address:

Street: _____

_____

Country: _____

DO YOU WANT INFORMATION REGARDING THE GROUP INSURANCE PROGRAM SENT TO YOUR DEPENDENT AS WELL AS YOU? **YES _____ NO _____**

Other Addressee: Federal law requires insurance plan administrators to provide claim-related information for covered dependents to the custodial parents. In order to do this, the address of the custodial parent must be provided to CMS. Address information also needs to be provided for individuals serving as power of attorney, legal guardian, or trustee of a covered dependent. Please provide the following information for any covered dependents who do not reside with you.

Name: _____

Street Address: _____

_____

City/State: _____Zip Code: _____

Relationship: (Check one)

Custodial Parent: _____

Trustee: _____

Power of Attorney: _____

Legal Guardian: _____

It is the member's responsibility to maintain correct mailing address information for dependents and/or custodial parents. The Group Insurance Representative is to be notified of any change in information.

Member Signature: _____ Date: _____

THIS FORM MUST BE RETURNED TO THE GROUP INSURANCE REPRESENTATIVE AT YOUR AGENCY.

04/2002

Part-time Employment and Election of Participation Certificate

Employee Name: _____ Employee SSN: _____

Effective Date of Part-time Status:_____ Part-time %: _____*

* If you are a part-time employee who works at least 50%, you are eligible to participate in the State Employees' Group Insurance Program.

Employees may elect to participate in the Group Insurance health and dental coverage voluntarily. Vision coverage is provided at no cost to employees participating in the health and dental coverage. Additionally, the State of Illinois provides Basic (i.e., term) Life coverage to part-time employees at no cost.

Before making your decision, you should carefully read the following:

1. If you choose to participate in the health, dental and vision coverage, you will be responsible for the state's portion of the health and dental premiums, based on the percentage of time employed. For example, if you work 75% time, the State will pay 75% of the state portion for your basic health and dental coverage. You would be required to pay the remaining 25% of the cost.
2. If you elect **not** to participate in health and dental, you will not be able to enroll in the program until the next Benefit Choice Period (coverage effective July 1 of each year), unless you experience an eligible Qualifying Change in Status.
3. Part-time employees cannot become a dependent of their state-employed spouse.
4. Provisions and conditions of the Group Insurance Program are applicable to you if you elect to participate in the program.
5. You must make a decision within ten (10) days of your effective date of part-time employment. The effective date of coverage for you and any eligible dependents will be retroactive to your employment date.

Please indicate your choice below and sign.

____ **YES**, I do want to participate in the coverage initialed below and understand I will be responsible for the corresponding premiums for the coverage:

Coverage Elected:

PT Premium Amount*	Type of Coverage	Member Initials
$ _____ /mo.	Health	
$ _____ /mo.	Dental	

* GIR/Ps should use the Deduction Calculation Screen (5C) to determine the amount of premium due from the member based on the part-time employee's percentage.

____ **NO,** I do not wish to participate in the health, dental or optional life coverage. I understand that I cannot change this election until the next Benefit Choice Period, unless I experience a Qualifying Change in Status.

_____ _____
Signature of Part-time Employee Date

_____ _____
Signature of Group Insurance Representative Date

The percentage of time is only a predicted figure for the purpose of determining the named employees eligibility to participate as a "not less than half time…" employee in the State Employees' Group Insurance Program

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

FSA CHANGE IN STATUS CERTIFICATION FY ___

Section 1 – Employee Information

Social Security Number *Last Name* *First* *Initial*

(The request for change in coverage must be initiated within 60 days of the change in status event.)

Section 2 –Type of Transaction

☐ Mid-Year Enrollment/New Hire* **If new hire, hire date**:_____
(A change in status event has occurred that will allow the participant to enroll in Flex outside of the normal Benefits Choice time.)

☐ Change in Status Event* (A change in status event has occurred that will allow the participant to change the current Flex account i.e.: ☐ Increase/Decrease Deduction amt, ☐ Add/Delete dependent(s).)

☐ Revocation

*Requires completion of Enrollment/Transaction Form

Section 3 - Eligible Event (Circle One)

01. Birth and adoption of dependent

02. Marriage

03. Divorce, legal separation, annulment

04. Death of dependent or spouse

05. Dependent becomes ineligible

06. Dependent becomes eligible for coverage

07. Change of county of residence/worksite for employee or spouse

08. Judgment, decree, or court order

09. Entitlement to Medicare or Medicaid

10. Employee Commencement of employment

11. Employee Returning from leave of absence

12. Employee Changing employment status - full-time to part-time < 50%

13. Employee Changing employment status – part-time <50% to full- time

14. Spouse or Dep Commencement of employment

15. Spouse or Dep Termination of employment

16. Spouse or Dep Returning from leave of absence

17. Spouse or Dep Changing employment status - full-time to part-time

18. Spouse or Dep Changing employment status – part-time to full-time

19. Employee entering leave of absence

20. Spouse entering leave of absence

21. Change in the cost of care

22. Employee Termination of employment/Death

Section 4 – Certification

I certify that the above eligible change in status event occurred on _____/_____/_____.

Employee Signature: _____ **Date** _____/_____/_____.

Return the completed form to your Group Insurance Representative.

Agency Use Only

Section 5 – Irrevocability and Consistency Determination
Compare the Event checked in Section 3 on the front of this form to the allowable changes in the chart below. The only changes allowable are those that are on account of and consistent with the nature of the Event. Note: Except for Revocations, the employee must also complete an Enrollment/Transaction Form.

	QUALIFYING CHANGE IN STATUS	**MCAP**				**DCAP**			
	X – Election allowed for the corresponding Qualifying Change Initial Enrollment – within 60 days	Enroll	Increase	Decrease	Revoke	Enroll	Increase	Decrease	Revoke
01	Birth and Adoption of dependent	X	X			*	*		
02	Marriage	X	X			X	X		
03	Divorce/Legal Separation/Annulment	*	*	*	*	*	*	*	*
04	Death of Spouse or Dependent			X	X			X	X
05	Dependent becomes Ineligible			X	X			X	X
06	Dependent becomes Eligible for Other Coverage			X					
07	Change of County of Residence/Worksite for Employee or Spouse	*	*	*					
08	Judgment, Decree, or Court Order	*	*	*	*	*	*	*	*
09	Entitlement to Medicare or Medicaid			X	X				
10	Employee Commencement of Employment	X				X			
11	Employee Returning from Leave of Absence	X	X			X	X		
12	Employee Changing Employment Status – Full-time to Part-time < 50%				X				X
13	Employee Changing Employment Status – Part-time < 50% to Full-time	X				X	X		
14	Spouse or Dep Commencement of Employment			X		X	X		
15	Spouse or Dep Termination of Employment	X	X	X					X
16	Spouse or Dep Returning from Leave of Absence	X	X			X	X		
17	Spouse or Dep Changing Employment Status – Full-time to Part-time	X	X					X	
18	Spouse or Dep Changing Employment Status – Part-time to Full-time			X		X	X		
19	Employee Entering Leave of Absence				X				X
20	Spouse Entering Leave of Absence	X	X	X					X
21	Change in the Cost of Care					X	X	X	X
22	Employee Termination of Employment/Death				X				X

*** Reviewed and approved on a case by case basis. Call the FSA Unit with any questions.**

Section 6 – Agency Approval (To be completed by Group Insurance Representative)**

GIR Signature: _____ Telephone ( ) _____-_____

Organizational Processing Code_____ _____ _____ Paycode _____

Date: _____/_____/_____

***Upon completion of the form, please forward the original to the FSA Unit at CMS, one copy to the participant, and retain one copy for your files.*

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

DEPENDENT CARE ASSISTANCE PLAN

ENROLLMENT/TRANSACTION FORM FY ___

Section A -Type of Transaction

☐ Benefits Choice Enrollment

☐ Mid-Year Enrollment/New Hire* (A change in status event has occurred that will allow the participant to Enroll in Flex outside of the normal Benefits Choice time)

☐ Change in Status Event* (A change in status event has occurred that will allow the participant to change their current Flex account i.e.: ☐ Increase/Decrease Deduction amount)

***** A Change in Status Certification must accompany this enrollment/transaction.

Section B – Employee Information

If initial enrollment, re-enrollment, or new employee, complete the entire form. If any other type of transaction, complete only the employee name, social security number and new information.

Social Security Number	*Last Name*	*First*		*Initial*
				( )
Street Address	*City*	*State*	*Zip Code*	*Home Phone*
				( )
Agency				*Work Phone*

Section C – Deduction Information and Authorization

Benefits Choice – The Number of Deductions will = 24 for Semi-monthly or Bi-weekly Pay or 12 for Monthly Pay.
– The Deduction Start Date is not required.

Outside Benefits Choice – You must work with your Group Insurance Representative to determine the Number of Deductions remaining for the year and the Deduction Start Date.

$_____ X _____ = $_____ | _____ / _____ / _____

Deduction Amt Per Pay | Number of deductions | DCAP Expenses | Deduction Start Date

I authorize the State of Illinois to deduct the above Deduction Amount Per Pay from each paycheck for DCAP.

Section D – Certification Statement (Please read carefully before signing)

I understand and certify that:

- *I may not change or stop my deposits to this account during the plan year unless I experience a qualified change in status.*
- *I will forfeit any unclaimed amount remaining in my account at the end of the run-out period.*
- *I understand that deductions must continue during any paid leave of absence and that I will not submit claims for expenses incurred during periods when I or my spouse are not actively working.*
- *I intend to participate in DCAP for the entire plan year. I do not anticipate terminating state service, retiring, or going on an unpaid leave of absence.*
- *I will refund to CMS any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed.*
- *If my payroll deductions cease for any reason, I understand I must complete the necessary paperwork and my participation in the program will terminate on the last day of the pay period for which a deduction was taken or the last day I was actively at work, whichever is sooner.*
- *To the best of my knowledge, the information on this form is accurate. I am responsible for any discrepancies that may affect my status with the Internal Revenue Service and I will comply with the IRS requirement to file an IRS Form 2441.*
- *I understand that if either I or my spouse earns less than $5,000.00, the DCAP contribution cannot exceed the lowest income.*
- *I understand that if my spouse is a full-time student or handicapped, the DCAP contribution cannot exceed $200.00/month for one child or $400.00/month for two or more children.*
- *I understand that if I and my spouse file separate federal income tax returns, DCAP contribution cannot exceed $2500.00.*

Employee Signature: _____ **Date** ____/____/____

Return the signed, completed form to your agency Group Insurance Representative

Section E –Agency Approval *(To be completed by Group Insurance Representative)**

Organizational Processing Code: _____ _____ _____ Paycode: _____

GIR Signature: _____ Date: _____/_____/_____

Telephone ( ) _____-_____

* Upon completion of the form, forward the original to the FSA Unit at CMS. Retain one copy of the form in the member's file and give another copy to both the participant and your payroll administrator.

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

MCAP COBRA Election Form

SECTION I: PARTICIPANT INFORMATION

Social Security Number — —	**Last Name**	**First Name**	**M.I.**
Date for Employment Termination, Unpaid LOA, or Retirement:			

SECTION II: CURRENT STATUS OF ACCOUNT

Current Account Balance as of ____/____/_____ : $ _____

1) Annual Elected Amount ..... $ _____

2) Current Year-To-Date Contributions (last deposit on _____/_____/_____) ..... $ _____

3) Additional Regular Payroll Contributions, if any ..... $ _____

4) Total Plan Year-To-Date Contributions upon Final Regular Payroll (add lines 2 and 3) ..... $ _____

5) **Balance Due to Meet Annual Elected Amount** (subtract line 4 from line 1) ..... $

SECTION III: PARTICIPATION/PAYMENT OPTIONS (for assistance contact the FSA Unit)

If the employee does not wish to continue participation, they must elect to terminate Plan Participation on this form. To continue plan participation, the employee must indicate their choice in the appropriate section and specify the payment option. The payment agreement must be honored in order to continue participation. **The employee must sign and date this form.**

☐ **I elect to continue participation** for the balance of the Plan Year by making my MCAP contributions by the method marked below. I understand that if I do not honor my payment agreement, my participation in the Plan will be terminated and I will not be eligible to file claims for expenses incurred after my period of participation and that I will not be eligible to resume participation if I am rehired by the State during the current Plan Year. **I understand that it is my sole responsibility to make any payments** by personal check or money order that are required **by the due date**, payable to the Flexible Spending Accounts Program and that I will not receive any notice of payments due or of non-payment.

☐ a) Full payment of Balance Due of $ _____ (from line 5) made on a pretax basis from any lump sum vacation or sick pay. If these funds are not sufficient to pay the balance due, I authorize payment of the full amount available, up to the amount listed in this option and will pay the difference by personal check or money order **within 45 calendar days** of my leave payment processing date.

☐ b) **Partial payment of $ _____ ($ _____ minimum)** made on a pretax basis from my annual or sick leave payment. The **Remaining Balance of $ _____** will be paid by personal check or money order **within 45 days** of the signature date on this form, or the processing of my leave payment, whichever occurs first. If leave funds are not sufficient to cover the designated partial payment, I authorize payment of the full amount available, up to the partial payment amount listed in this option. I will meet my Remaining Balance Payment by personal check or money order accordingly.

☐ c) **Full payment of $ _____** paid by personal check or money order within 45 calendar days of the signature date on this form.

☐ d) **Monthly payments** by personal check or money order due on the **first day of each month**.

Number of payments ____ of $ _____ beginning ___/___/_____

Payments are due on the first day of each month.

☐ **I elect to terminate Plan Participation.** I understand that any claims for expenses incurred after my period of participation will not be eligible for reimbursement.

PARTICIPANT SIGNATURE: _____ **DATE:** _____

GROUP INSURANCE REPRESENTATIVE SIGNATURE: _____ **DATE:** _____

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

MEDICAL CARE ASSISTANCE PLAN

ENROLLMENT/TRANSACTION FORM **FY ___**

Section A – Type of Transaction

☐ Benefits Choice Enrollment

☐ Mid-Year Enrollment/New Hire* (A change in status event has occurred that will allow the participant to Enroll in Flex outside of the normal Benefits Choice time)

☐ Change in Status Event* (A change in status event has occurred that will allow the participant to change their current Flex account i.e.: ☐ Increase/Decrease Deduction amount)

***** A Change in Status Certification must accompany this enrollment/transaction.

Section B – Employee Information

If initial enrollment, re-enrollment, or new employee, complete the entire form. If any other type of transaction, complete only the employee name, social security number and new information.

Social Security Number	*Last Name*	*First*	*Initial*
			( )
Street Address	*City*	*State*	*Zip Code*	*Home Phone*
			( )
Agency			*Work Phone*

Section C – Deduction Information and Authorization

Benefits Choice – The Number of Deductions will = 24 for Semi-monthly or Bi-weekly Pay or 12 for Monthly Pay.
– The Deduction Start Date is not required.

Outside Benefits Choice – You must work with your Group Insurance Representative to determine the Number of Deductions remaining for the year and the Deduction Start Date.

$_____ X _____ = $_____ | _____ / _____ / _____

Deduction Amt Per Pay | Number of deductions | MCAP Expenses | Deduction Start Date

I authorize the State of Illinois to deduct the above Deduction Amt Per Pay from each paycheck for MCAP.

- ***over –***

Section D – EZ Reimburse Card

- ☐ Yes! I want the EZ REIMBURSE card.
  - There is an annual fee of $20.00 per participant, per plan year. This fee is waived for FY2005.
  - There is a $10.00 fee for replacement per card.
  - There is a $5.00 fee for any additional cards.
  - In the event an ineligible expense is incurred, the participant will be notified for repayment.

Section E – Certification Statement (Please read carefully before signing)

I understand and certify that:

- *I may not change or stop my deposits to this account during the plan year unless I experience a qualified change in status.*
- *I will forfeit any unclaimed amount remaining in my account at the end of the run-out period.*
- *I understand that deductions must continue during any paid leave of absence.*
- *I intend to participate in MCAP for the entire plan year. I do not anticipate terminating state service, retiring, or going on an unpaid leave of absence.*
- *I will refund to CMS any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed.*
- *I understand that services incurred after my payroll deductions or direct monthly payments (as a result of COBRA) cease, are ineligible for reimbursement.*
- *If my payroll deductions cease for any reason, I understand I must complete the necessary paperwork and my participation in the program will terminate on the last day of the pay period for which a deduction was taken, unless I elect to continue my participation through direct payments to the FSA Unit.*
- *To the best of my knowledge, the information on this form is accurate. I am responsible for any discrepancies that may affect my status with the Internal Revenue Service.*

Employee Signature: _____ **Date** ____/____/____

Return the signed, completed form to your agency Group Insurance Representative

Section F – Agency Approval ***(To be completed by Group Insurance Representative)****

Organizational Processing Code: _____ _____ _____ Paycode: _____

GIR Signature: _____ Date: _____/_____/_____

Telephone ( ) _____-_____

* Upon completion of the form, forward the original to the FSA Unit at CMS. Retain one copy of the form in the member's file and give another copy to both the participant and your payroll administrator.

CMS ILLINOIS DEPARTMENT OF
CENTRAL MANAGEMENT SERVICES

ILLINOIS STATE EMPLOYEES GROUP INSURANCE PROGRAM

MINNESOTA LIFE OPTIONAL LIFE DEDUCTION REPORT

University _____ Payroll Code(s) _____

Date of Transmittal Listing _____ Prepared by _____

Phone # _____ Date _____

Date of Check (1)	Check Number (2)	Dollar Amount (3)	Type of Payroll (S/M, Monthly) (4)	Coverage Period (5)	Remarks (6)

Total of Transmittal $ _____